Referral Form for Inpatient Forensic Evaluation

Receiving Facility: _____

Referring Agency: _____

Date of Referral: _____ Date of Outpatient Evaluation: _____

Name of Service Recipient: _____

Social Security Number: _____ Date of Birth: _____

Docket #: _____

Date(s) of Alleged Crime: _____ Current Location/Placement: _____

County: _____ Prosecutor: _____

Judge: _____ Defense Atty: _____

Charge(s): Felony: _____

Misdemeanor:_____

Clinical Information:

List All Interventions Used to Prevent Referral: ____ Malingering Exam ____ Medication Intro/Adjust

____ Contacted Judge or Attorney(s) ____ Competency Training ____ Psychological Testing (specify):_____

____ Other (specify): _____

Reason for Referral to Inpatient Facility: (Specify Clinical Rationale - Do Not State "For Forensic Evaluation")

Reason for Referral to FSP [ADULT ONLY] (Specify Clinical Rationale)**:**

Current Medications:

Current Medical Concerns:

Current and/or Previous Mental Health Treatment: Yes _____ No _____

Facility: _____

Past Forensic Evaluation (Where and When):